COMMUNITY CARE LICENSING DIVISION

"Promoting Healthy, Safe and Supportive Community Care"

TECHNICAL SUPPORT PROGRAM

Self-Assessment Guide

GROUP HOME PREADMISSION QUESTIONNAIRE

CDSS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

TECHNICAL SUPPORT PROGRAM

GROUP HOMES

PREADMISSION QUESTIONNAIRE

The following questionnaire is designed to assist group home staff to identify specific issues that may affect the placement of and/or services to be provided to prospective residents of Group Homes (GH). Depending upon the needs of the child and facility program additional information may need to be gathered prior to the placement of a child in the facility. The questions on this form should be reviewed with the child's placement worker prior to admission to the facility. If the answer to any of the questions on this form is yes; the intake staff should gather information to determine whether or not the facility will be able to admit the resident and meet his/her needs.

The information on this form supplements the Needs and Services Plan form (LIC 625), but does not replace it. While the information gathered from this form should assist staff in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date: ___/___/___

Child's Name: _____

Current Residence: _____

Placement Status: Voluntary_____ 300 W&I_____ 602 W&I_____

Reason for Placement: _____
_____
_____
_____

YES	NO	
☐	☐	Is the child a registered sex offender? (Information required per H & S 1522.01) If yes, please provide information on offense(s): _____ _____ _____

A. ABUSE/NEGLECT

Does the child have a history as a victim of any of the following:

YES	NO		
☐	☐	1.	Physical abuse
☐	☐	2.	Sexual abuse
☐	☐	3.	Abandonment
☐	☐	4.	Emotional abuse
☐	☐	5.	Neglect
☐	☐	6.	Medical neglect
☐	☐	7.	Ritualistic abuse

ABUSE/NEGLECT (continued)

If the answer to any of the above questions is yes, please describe:

The type and extent: _____
_____
_____
_____

Any therapy the child has received or requires: _____
_____
_____
_____

Any special precautions to be taken in the care of the child: _____
_____
_____
_____

B. DELINQUENCY

Does the child have a history of any of the following:

YES	NO		
☐	☐	1.	Offenses against people
☐	☐	2.	Offenses against property
☐	☐	3.	Drug or alcohol related offenses
☐	☐	4.	Use of weapons
☐	☐	5.	Arson
☐	☐	6.	Sexual Offenses
☐	☐	7.	Truancy
☐	☐	8.	Runaway
☐	☐	9.	Gang activity

If the answer to any of the above questions is yes, please describe:

The type and frequency of the activity: _____
_____
_____
_____

The approximate date of the last involvement in the activity: _____

Gang affiliation, if any: _____
_____
_____
_____

C. MENTAL/DEVELOPMENTAL STATUS

Do any of the following apply to the child:

YES	NO		
☐	☐	1.	Mental disorder (DSM, current revision, diagnosis)
☐	☐	2.	Developmental disability
☐	☐	3.	Deficits in self help skills
☐	☐	4.	Requires psychotropic medications
☐	☐	5.	Special education pupil, certified, Seriously Emotionally Disturbed (SED)

If the answer to any of the above questions is yes, please provide the following information:

Is the child eligible for and/or receiving services through a Regional Center? If yes, please give the provider name and summary of services: _____
_____
_____
_____

Does the child have a DSM diagnosis? If yes, please list any past or current treatment: ___
_____
_____
_____

Has the child ever been an inpatient of a mental health facility or developmental center? If yes, please provide the dates, reasons, and location of hospitalizations: _____
_____
_____
_____

D. HEALTH STATUS

Child's primary physician's name: _____

Phone number: (____) ____ - _____

YES	NO	
☐	☐	Does the child use any prescription medications? If yes, please list prescription: _____ _____ _____ _____
☐	☐	Does the child use any nonprescription medications? If yes, please list nonprescription: _____ _____ _____ _____

HEALTH STATUS (continued)

Does the child have any of the following:

YES	NO		
☐	☐	1.	Asthma
☐	☐	2.	Epilepsy
☐	☐	3.	Allergies
☐	☐	4.	Diabetes
☐	☐	5.	Eating disorder
☐	☐	6.	Visual impairment
☐	☐	7.	Hearing impairment
☐	☐	8.	Infectious disease
☐	☐	9.	Special diet
☐	☐	10.	Pregnancy
☐	☐	11.	Chronic medical conditions
☐	☐	12.	Physical limitations

If the answer to any of the above is yes, please describe:

The type and severity of the condition: _____
_____
_____
_____

The treatment the child is receiving for the condition: _____
_____
_____
_____

Any medical apparatus the child needs as a result of the condition: _____
_____
_____
_____

Any limitations due to the condition: _____
_____
_____
_____

Any special services required due to the condition: _____
_____
_____
_____

E. ALCOHOL/DRUG USE

Does the child have a history of any of the following:

YES	NO		
☐	☐	1.	Drug use
☐	☐	2.	Alcohol use
☐	☐	3.	Use of inhalants
☐	☐	4.	Use of injectable drugs
☐	☐	5.	Treatment for drug abuse
☐	☐	7.	Abuse of over-the-counter medications

If the answer to any of the above is yes, please describe:

Types of drugs, alcohol or inhalants used: _____
_____
_____
_____

Frequency of use of the above: _____
_____
_____
_____

Approximate date of last known use of the above: _____
_____
_____
_____

Current or past treatment programs for substance abuse and dates of treatment: _____
_____
_____

F. BEHAVIORS

Does the child have a history of any of the following:

YES	NO		
☐	☐	1.	Non-compliance
☐	☐	2.	Resistance to authority
☐	☐	3.	Temper tantrums
☐	☐	4.	Verbal abusiveness
☐	☐	5.	Physical assaultiveness
☐	☐	6.	Property destruction
☐	☐	7.	Violence toward self
☐	☐	8.	Restlessness or hyperactivity
☐	☐	9.	Depression or withdrawal
☐	☐	10.	Anxiety

BEHAVIORS (continued)

If the answer to any of the above is yes, please describe:

The behaviors: _____
_____
_____
_____

The frequency and duration of the behaviors: _____
_____
_____
_____

The approximate date of the last occurrence of the behaviors: _____
_____
_____
_____

Anything that seems to trigger the behaviors: _____
_____
_____
_____

Strategies to deal with the behaviors: _____
_____
_____
_____

Does the child have a history of any of the following:

YES	NO		
☐	☐	1.	Mood swings
☐	☐	2.	Suicidal ideations
☐	☐	3.	Suicide attempts
☐	☐	4.	Paranoia
☐	☐	5.	Hallucinations
☐	☐	6.	Fire setting
☐	☐	7.	Cruelty to others
☐	☐	8.	Cruelty to animals
☐	☐	9.	Inappropriate sexual behavior
☐	☐	10.	Confusion with sexual identity

If the answer to any of the above is yes, please describe:

The behaviors: _____
_____
_____
_____
_____

BEHAVIORS (continued)

The frequency and duration of the behaviors: _____
_____
_____
_____

The approximate date of the last occurrence of the behaviors: _____
_____
_____
_____

Anything that seems to trigger the behaviors: _____
_____
_____
_____

Strategies to deal with the behaviors: _____
_____
_____
_____

Does the child have a history of any of the following:

YES	NO		
☐	☐	1.	Sexual assualtiveness
☐	☐	2.	AWOL
☐	☐	3.	Ingestion of toxic substances
☐	☐	4.	Attempts to poison others
☐	☐	5.	Disruptiveness
☐	☐	6.	Refusal to take medications
☐	☐	7.	Refusal of medical treatment
☐	☐	8.	Refusal to attend therapy
☐	☐	9.	Stealing
☐	☐	10.	Other (describe) _____

If the answer to any of the above is yes, please describe:

The behaviors: _____
_____
_____
_____
_____

The frequency and duration of the behaviors: _____
_____
_____
_____
_____

BEHAVIORS (continued)

The approximate date of the last occurrence of the behaviors: _____
_____
_____
_____
_____

Anything that seems to trigger the behaviors: _____
_____
_____
_____

Strategies to deal with the behaviors: _____
_____
_____
_____
_____

Placement Worker: _____

Phone Number: (____) _____-_____ extension: _____

Facility Representative: _____